CLAIM FORM 1: REIMBURSEMENT
FOR OUT-OF-NETWORK BENEFIT

Out-of-Network Claims if you have Out-of-Network Benefits

Use this form if you receive vision services from an out-of-network eyecare provider and you have out-of-network benefits. If your plan does not include out-of-network benefits, please see the Network Exceptions form, claim form 2, for separate processing instructions.

To request reimbursement, please complete and sign the itemized claim form. Return the completed form and your itemized paid receipts to:

Cigna Healthcare Claims Department
c/o First American Administrators, Inc.
Attn: OON Claims, PO Box 8504, Mason, OH 45040-7111

Patient Last Name† **Patient First Name**† **MI**

Birth Date (MM/DD/YYYY)† **Street Address**†

City† **State**† **Zip Code**†

Patient Customer ID #

Relationship to Subscriber†
Self ◯ Dependent ◯

†Required

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Subscriber Last Name† **Subscriber First Name**† **MI**

Birth Date (MM/DD/YYYY)† **Street Address**†

City† **State**† **Zip Code**†

Vision Plan Name
Cigna Healthcare

Date of Service† (MM/DD/YYYY)

Vision Plan Group #

Subscriber Customer ID #

Provider or Retailer where patient received services

Provider's Name† **Provider's NPI**

Provider Street Address†

City† **State**† **Zip Code**†

†Required

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged
Exam *92014*	$
Refraction *92015*	$
Frame *V2025*	$
Contact Lens *S0500*	$
Contact Lens Fitting *92310*	$
Lenses	$

Lens Type	Please Check
Single *V2100*	☐
Bifocal *V2200*	☐
Trifocal *V2300*	☐
Progressive *V2781*	☐
Prem Prog *V278126*	☐
Other	$

Lens Options: (if purchased)	Amount Charged
Anti-Reflective *V2750*	$
Polycarbonate *V2784*	$
Scratch *V2760*	$
Tint *V2745*	$
UV *V2755*	$
Roll and Polish *V2702*	$

Enter Total Amount Paid as shown on receipt, excluding sales tax† $

I certify that I have read the state fraud warnings. If I want a printed copy, I can contact the customer call center at 1.888.353.2653. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Customer/Guardian/Patient Signature (not a minor)† **Date**

†Required